Developing Cultural Understanding through Empathy : Insights from Narrative Medicine for the ESL/EFL Classroom

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Introduction

Despite widespread understanding of the relationship between culture and language, and the recognition in academic circles of the benefits of cultural instruction to foreign-language students, teaching culture to foreign-language learners remains a contentious subject. Disregard for culture is particularly evident in literary texts for foreign-language instruction, where inclusion of cultural information and reference to cultural perspectives are noticeably absent.

This research paper introduces the field of narrative medicine. Narrative medicine utilizes literature to develop empathetic understanding of outgroups in medical practitioners and caregivers. Through reading, analyzing, and discussing narratives, practitioners and caregivers gain understanding of their foreign patients' emotional and physical needs, their culture, and life situations. Narrative literature is a component of medical training in institutions around the world, yet it remains largely unrecognized in foreign language education—despite the shared goals in these fields of promoting understanding of people, improving interpersonal communication and developing sensitivity to cultural groups. This research aims at the following objectives:

1. to briefly outline the current status of literature in foreign-language

education;

2. to introduce aspects of narrative medicine's theory and practice;
3. to consider how the concepts of narrative medicine might be implemented in foreign-language teaching.

Language, culture, and foreign-language education

Research into the interrelatedness between culture and language began with Edward Sapir (1929). Sapir wrote that "the real world is to a large extent unconsciously built up on the language habits of the group" (p. 209). Carrying forward many of Sapir's arguments, Benjamin Lee Whorf conceptualized languages as culturally-ordained representations dictating not only how groups communicate, but also the manner in which an individual "analyzes nature, notices or neglects types of relationships and phenomena, channels his reasoning, and builds the house of his consciousness" (Whorf, Carroll, & Chase, 1956, p. 252). This understanding is echoed by Wardhaugh (2010), who asserts that language structures function to shape the worldview of their speakers. Similarly, Kramsch (1998) presents language as the primary vehicle—and store of cultural identity—through which cultural reality is expressed.

Emerging from concepts of linguistic-cultural connectedness is the belief that language acquisition and cultural understanding are optimally acquired at the same time (Schultz, 2007). Teaching culture to ESL/EFL learners is not a novel topic; on the contrary, it is a subject that has been discussed over many years (see Lazar, 1993; Brown & Eisterhold, 2004; Tang, 2006).

However, the first decade of the 21st century witnessed a decline in scholarship focused on developing effective methods for the integration of culture in second and foreign-language classrooms (Tran, 2010). This wane

in enthusiasm (for the integration of culture) may have been due to the inability of academics to achieve consensus on the issue (Dema & Moeller, 2012). From the perspective of the language teacher, taking on the role of cultural ambassador in the classroom can be perceived as burdensome. He or she may feel disinclined or unqualified to discuss another language group's culture. (Byram & Kramsch, 2008; Crawford-Lange & Lange, 1984).

Some language teachers respond by narrowing the discussion of culture to fact-based content. Galloway (1981) categorizes such curricular attempts as *The 4-F Approach* (folk dances, festivals, fairs, and food), and *The Tour Guide Approach* (identification of monuments, rivers, and cities), in her criticism of teachers for emphasizing cultural information instead of helping students gain deeper understanding of cultures. Such criticism reinforces the conclusions reached by academics within the field of intercultural competence—that cultural knowledge itself is insufficient for development of meaningful cultural understanding (see Bennett, 2005; Byram 1997). Seelye (1984) argues for the necessity of teachers to engage in a deeper teaching of culture, giving attention to the thoughts and emotions of members of other cultures in addition to cultural contexts. Byram (1989) similarly insists that educators should focus on the hidden curriculum, "the part of foreign-language teaching which conveys information, attitudes, images and perhaps even prejudice about the people and countries where the particular language is spoken" (p. 1).

Literature for cultural understanding

Various educators have advocated for the use of literature as an alternative to information-heavy approaches to culture in the language classroom. In their introduction to using literature in ESL/EFL, Carter and

Long (1991) in *Teaching Literature* argue for the importance of employing literature not only for the transmission of cultural information, but also for the engendering of cultural understanding vis-à-vis groups of perceived "others." Described as the *cultural model*, the authors state:

> Teaching literature within a cultural model enables students to understand and appreciate cultures and ideologies different from their own in time and space and to come to perceive tradition of thought, feeling, and artistic form within the heritage the literature of such cultures endows. (1991, p2.)

The concept of using literature to facilitate cultural understanding and awareness has been promoted in various ways. Collie and Slater (1987) speak about the barriers to cultural understanding present when language learners do not have direct access to the target culture. Describing how literature can develop understanding for language learners Collie and Slater write:

> [T] he 'world' of a novel, play, or short story is a created one, yet it offers a full and vivid context in which characters from many social backgrounds can be depicted. A reader can discover their thoughts, feelings, customs, possessions; what they buy, believe in, fear, enjoy; how they speak and behave behind closed doors. (p. 4)

A variety of foreign-language researchers and educators have recognized literature's capacity to foster cultural understanding in recent years, (see Bobkina & Dominguez, 2014; Byrnes, 1991, Galloway, 1992; Hadley, 1993; Teranishi, 2015); yet the intentional use of literature to teach culture remains an under-utilized pedagogical strategy (McCormack, 2018). The benefits of literature for foreign-language learners are balanced by a series of difficult questions, such as *whose culture* educators should seek to transmit to language learners. Citing Searle (1984) and Thiong'o (1992),

Lazar (1993) notes that "frequently, the teaching of literature is identified with the imposition of particular imperialistic values" (p. 16).

A less political and more practical concern for foreign-language educators is whether the particular aspects of culture portrayed in a given text are authentic, realistic and relevant. The decision to use works of literature is accompanied by thorny discussions among academics regarding who gets to tell what about whose culture. It is perhaps understandable that EFL/ESL educators who integrate literature into their lessons focus on other language-learning objectives rather than cultural understanding.

Introducing narrative medicine

This research now turns to a discussion of the field of narrative medicine, pioneered by Rita Charon at Columbia University (2001), and by John Launer (Zaharias, 2018). While medical training programs might seem an unusual place to find literature in the curriculum, the growing use of narratives in this field has developed in response to a critical medical concern: young physicians and caregivers often have difficulty interacting sensitively with patients who differ from them in age, medical condition, economic status, and sociocultural background. Dr. John Lantos (2011) describes the problem:

> The medical students and pediatric residents who work with me are often frustrated by something about this work and these patients. The diseases are, in some vague but important sense, uninteresting diseases. Usually, there are no diagnostic dilemmas. My patients require care that is relatively low tech…. Year after year, residents "rotate" through the chronic disease hospital, and year after year,

> I get to watch them struggle with the challenges. Some give up almost immediately. The giving up takes the form of retreating into a narrow technical approach to the care of these chronically ill patients. Such residents stick to careful attention to medications, and remain uninvolved in broader aspects of care. (p. vii)

By "broader aspects" Lantos is referring those facets of caregiving that recognize and respect the humanity of the sufferer—the ability of the physician to imagine patient mental states and provide care informed by these insights. Contrary to public perception, many medical trainees find the practice of medicine routine; these trainees can become indifferent toward patients who have chronic illnesses which do not improve. For Lantos, such trainees present a difficult educational issue: how to train medical students to respond with compassion and sensitivity to patients suffering from health conditions they are unable to relate to. Physicians who cannot relate to their patient's health condition, and perhaps in addition, cannot relate to their patient's age group, culture, or socioeconomic background, may, consequently, deliver sub-optimal service to the patient. Recognizing this challenge, the field of narrative medicine attempts to humanize patients, thereby enlarging physicians' capacity to understand and empathize, and ultimately improving their standard of service.

Narrative medicine began in the 1990s with the practice of compiling narratives. Physicians-in-training sat down with patients to hear their narratives—life stories told from the patient's perspective. By hearing and writing down their stories, trainees began to comprehend the patient's suffering (Charon, 2001). Charon (2004) describes the benefit of these patient narratives:

> Capacities that medicine now sometimes lacks—attunement

> to patients' individuality, sensitivity to emotional or cultural dimensions of care, ethical commitment to patients despite fragmentation and subspecialization, acknowledgment and then prevention of error—may be provided through a rigorous development of narrative skills. (p. 863)

Rather than treating illness with clinical detachment, narrative medicine emphasizes the story-like experience of illness, primarily through the understanding of the patient's thoughts and feelings, but also through an understanding of the physician's role in the patient's narrative. Physicians-patient communication is often hampered by disconnects, or divides. Charon (2006) describes these divides as: i) the relation to mortality (the tendency of physicians to treat illness clinically versus the typical patient response of fear and anguish at the prospect of dying); ii) the context of illness (the tendency of physicians to view illness as a separate event versus the patient's view of illness as a life-altering event); iii) beliefs about disease causality (physician/patient misunderstandings regarding causes and symptoms of illness); and iv) the emotions of shame, blame and fear (emotions that discourage patients from confiding information and discussing their illness openly). According to Charon (2001), "By bridging the divides that separate physicians from patients… narrative medicine offers fresh opportunities for respectful, empathic, and nourishing medical care" (p. 1897).

Improving physician/patient communication through literature

Narrative literature used in medical training programs consists of stories told from different vantage points: from the patient's point of view, about the patient told by the patient's family, stories told by the

hospital staff, and even stories told by other doctors. These stories help doctors-in-training to engage in *perspective-taking*, a cognitive empathic ability defined by Goldie (2000) as "a process by which a person centrally imagines the narrative (including the thoughts, feelings, and emotions) of another person" (p. 195). Perspective-taking develops empathic concern, an affective (i.e., emotional) response defined as "an other oriented emotional response elicited by and congruent with the perceived welfare of a person in need" (Batson, Eklund, Chermok, Hoyt, & Ortiz, 2007, p. 64). In taking another's perspective, the trainee gains insight into the patient's mental states and experiences feelings of genuine concern. This concern motivates the trainee to engage in helping behaviors (Hodges & Myer, 2007). Eliciting empathic concern and helping behaviors: these are the goals of narrative medicine.

The literature-based approach to empathic development has been adopted by the medical profession for largely practical reasons, as didactic approaches (i.e., direct instruction outlining the benefits of empathizing with patients) have been demonstrated to be ineffective (Henry Tillman, Deloney, Savidge, Graham, & Klimberg, 2002). While medical curricula continue to teach the importance of developing empathy, training programs now widely incorporate narratives to activate physician empathy.

Narrative, simply defined, is "a story or a description of events" (*Cambridge Dictionary*, 2020). It is a story, varying in length, and written down in text. Reading a story involves discourse, which literary critic Barbara Herrnstein Smith (1980) defines as "someone telling someone else that something happened" (p. 232). In this way, there are two parties involved in a narrative: the storyteller and the listener. The processing of literary narratives activates *narrative empathy*, "the sharing of feeling and

perspective taking induced by reading, viewing, hearing, or imagining narratives of another's situation and condition" (Keen, 2013, "narrative empathy," para 1). As physicians read and reflect on stories, they leave the narrow world of medical textbooks and clinical case evaluations, to enter worlds where patients and patient families struggle to understand and cope with the challenges of illness, and where care givers and their work becomes humanized.

To illustrate this process, Charon (2012) cites two accounts of a patient death. Below is the standard medical report:

> On Admission: Patient walked in bleeding profusely from the mouth. Pulse strong, at first rapid, later slowed down. Ord. Ergot, tannic acid solution.
>
> Sept 1: Feels better this AM. Ord. Ergot
>
> Sept 3: Very weak and short of breath, still spits blood clots.
>
> Sept 4: Very much weaker. Infusion Digitalis. Growing cyanotic, still raising blood.
>
> Sept 5: Patient gradually sank at 8 am. No radial pulse. Temperature 105 and at 9:15, quietly died. ("Narratives of Clinical Practice," para. 7)

Contrast the above account with an experience of this patient's death as related by a third year medical student:

> I saw one patient die. They had just announced a code overhead, and we ran, and my resident was doing chest compressions, and everything, and pushing the drugs, and all that, and then, at the end, they called—you know, the time of death, and it was over, and then everyone like, walked out of the room…[U]h, everyone walked out of the room, and the patient was just lying on the bed, naked.

> She had her head bent back, and the tube in her throat, and tape across her face, trying to hold it down, and her groin was all bloody from the multiple ABGs [arterial blood gas tests] we had done, or sent, and it just looked very horrible, and it was just very—everyone just left, like, they were like, okay, it's over now, and just left. ("Narratives of Clinical Practice," para. 12)

Although concise and accurate, the first account offers little insight into the emotional experience surrounding the patient's death—a traumatic experience for both medical practitioners and family members, not to mention the patient. The second narrative, while short, immediately accesses the horror and despair of someone experiencing the patient's death firsthand. Through the student's eyes, the reader is given the opportunity not only to enter into the medical student's response, but also consider how he/she would feel in such a situation. In this way, narrative medicine employs literature to activate physician consciousness. Reflection on the narrative helps trainees consider how patient care might have been handled in a better way. For Charon, this is the function of narrative: to humanize others, to stimulate self-reflection, and to instruct.

Improving understanding and awareness through empathy

A number of studies have shown narrative medicine-based training to increase physician empathy. Welch and Harrison (2016) conducted a four-week literature course (using a variety of genres: novels, short stories, poems, nonfiction medical narratives) in which patient suffering was presented from various perspectives. Readings were accompanied by written reflections and group discussions. The researchers describe the benefits of the course as follows:

1. Enhanced students' ability to listen and interpret their patient's story, even in difficult and ambiguous situations.
2. Provided students with the opportunity to contemplate difficult questions before they occurred in clinical practice.
3. Helped uncover biases and enhanced empathy.

(Welch & Harrison, 2016, "Course Structure," para. 4).

In a post-course survey, participants in the course reported increased ability to take patients' perspectives, engage in self-reflective thinking, and to mitigate discussions on sensitive topics.

Shapiro, Morrison, and Boker (2004) studied the effects of an eight-week literature course on the attitudes of first-year medical students. In the course, students reflected on patient narratives, and participated in group discussions where they voiced their opinions and learned from one another. The readings covered topics such as patient suffering, doctor-patient relationships, and cross-cultural issues. Describing the curriculum themes the researchers write:

> We placed special emphasis on understanding of, and identifying with, different points of view in the texts, including those of physicians, patients, and family members, as well as their own. (p. 76)

Shapiro, Morrison, and Boker demonstrated a rise in student empathy on an empathy instrument. They concluded that "after a relatively brief exposure to literature, students also had a more sophisticated understanding of patients" (p. 82). These results correspond with findings in psychology regarding the ability of narrative reading to raise empathy scores (see Koopman & Hakemulder, 2015; Mar, Oatley, Hirsh, & Peterson, 2009; Oatley, 1995; 1999).

Narratives have been employed to facilitate a wide range of perspective-

taking with positive results reported. DasGupta and Charon (2004) conducted a course entitled *Reading the Body, Writing the Body: Women's Illness Narratives*, in which students read patient narratives to gain an understanding of female patients. Students were asked to write down their reflections, and as an additional exercise, to write about a personal illness experience or the experience of someone with whom they had a close relationship. At each session, the instructor guided the students to rewrite their text "by changing narrative aspects of their essays—changing, for example, the genre, the temporal dimension, or the voice" (p. 353). Post-course questionnaire results were analyzed, from which the researchers concluded:

> [T] he personal illness narrative exercise enables medical students to articulate and examine feelings and thoughts about bodily realities of illness, health, and selfhood. Students are able to witness, interpret, and translate their own and each others' experiences to gain a better understanding of themselves as practitioners and, in turn, of their patients. (p. 355)

In order to expand physician understanding of patients' socioeconomic and cultural backgrounds, DasGupta, Meyer, Calero Breckheimer, Costley, and Guillen (2006) organized a narrative reading and discussion program that attempted to "place students directly in contact with the community outside of the medical institution" (p. 14). Physicians met regularly to discuss chapters of the novel *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*. In this novel, patients from a non-English-speaking culture have difficulty communicating with their English-speaking doctor. In a survey following the course, participants reported an increase in their understanding of how language and cultural differences cause problems for doctors and patients.

Empathy and cultural competence

At its core, narrative medicine promotes the development of medical trainees' empathy through reading, reflection, and discussion of literary narratives written from various perspectives. Through developing perspective-taking ability, educators in the field believe that young physicians can gain deeper insight, understanding and sensitivity towards patients whose background and language differs from their own. This reasoning is congruent with research in the fields of intercultural communication and intercultural competence, in which empathy has been consistently identified as a required component for development (see Deardorff, 2006; Fantini, 2009; Fantini & Tirmizi, 2006).

In identifying learner stages of intercultural competence, Milton Bennett (1986) put forward a *Developmental Model of Intercultural Sensitivity* in which perspective-taking ability factors large. According to Bennett (1993), in order to reach higher stages of competence, learners must develop the ability to "empathize or take another person's perspective in order to understand and be understood across cultural boundaries" (p. 17). He states that "people at adaptation (an advanced state of intercultural competence) can engage in empathy—the ability to take perspective or shift frame of reference vis-à-vis other cultures" (2004, p. 68). Bennet's intercultural competence model is supported by Arasaratnam (2006), who proposes an *Integrated Model of Intercultural Communication Competence*, and King and Baxter Magolda (2005), who put forward an *Intercultural Maturity Model*.

Narrative medicine and foreign language education

Narrative medicine provides a blueprint for foreign-language educators who wish to incorporate cultural components into existing curricula. Literary

narratives written from various cultural backgrounds can be incorporated into existing curricula to bring about a deeper understanding of other cultures. Unlike informational or didactic approaches to teaching culture, narratives allow the learner to see the world through the protagonist's eyes. The final sections of this research will offer suggestions for adapting strategies from narrative medicine for use in foreign-language education.

To begin with, literary selections in narrative medicine are primarily based on the ability of a given story to "speak" to readers (i.e., to convey a particular experience). Narratives need not be grammatically complex, and they may vary greatly in their level of reading difficulty, but they are first-hand (such as Charon's example provided earlier), authentic, and accessible. The stories used in medical training deal primarily with experiences related to disease and treatment, but other stories in the foreign-language classroom may be selected for their ability to present the experience of different cultures through the perspectives of members *from those cultures*.

Strategies for teaching empathy in narrative medicine are compatible with interactive approaches propounded in communicative language teaching (CLT). Whether learners choose to read individually or in groups, they both teach and learn from each other when they share their reflections. Furthermore, the cycle of reading, reflecting, and discussing covers a wide range of teaching objectives that can be adjusted for learners at various levels, just as narratives may be selected to meet learner reading levels.

Narratives give the ESL/EFL educator the ability to achieve more. Level-appropriate narratives present learners with an interesting medium through which to practice basic language skills (reading, writing, speaking), and at the same time develop perspective-taking skills requisite

for deep cultural understanding. Research from narrative medicine suggests that reading, combined with written reflection and discussion, is an effective strategy for increasing learner sensitivity and awareness of other peoples' conditions, needs, and emotional states. This strategy is compatible with the goal of foreign-language educators: that of preparing learners for successful global citizenship.

While the use of literature is not new to foreign-language teaching, narrative medicine's educational strategies are instructive concerning how it may be integrated effectively. Narratives should be selected based on their ability to convey experiences, and as such may be as brief as a single paragraph. Indeed, short fiction and non-fiction narratives are often received by learners with less trepidation than short stories or excerpts from longer works. Ostman (2018; 2019) reported the use of short immigrant narratives and flash fiction in EFL classes with positive results. The following section introduces a sample lesson from his study.

A Korean in Germany – An example class

Consider the following short narrative introduced by the author in a 90-minute first-year undergraduate course at a Japanese university:

> *My parents are both from Korea, and emigrated separately from Korea to Germany during the early 70s. Later on, they met each other there. During the first year, my mom was too afraid to eat any of that "weird" German food, so she only ate rice she bought through friends and the vegetables she was able to find that she had eaten in Korea. In the end she got tired of eating only these foods and decided to visit a supermarket. While looking at all the different foods, she noticed a horrible smell. She first thought that somebody had vomited, but couldn't see anything on the floor. In the end*

she ran away because the smell was too unbearable. That was the first time she encountered cheese. (anonymous)

The lesson plan consisted of the following components:

1. Pre-reading exercises
2. Narrative reading
3. Cultural investigation
4. Reader reflection

In a pre-reading exercise, readers were asked to recall or imagine a situation in which they were asked to eat unfamiliar food they thought they would dislike. Pre-reading exercises, such as this, prepare the reader to engage empathically with the characters in the narrative. Smith (1989) observes that subjects are more likely to respond empathically to people with whom they perceive similarities, a tendency that Batson, Duncan, Ackerman, Buckley, and Birch (1981) have demonstrated through experiment. Students were then asked to consider how they might react to some examples of unfamiliar foods (e.g., haggis, chicken's feet, blood pudding, etc.). Students were asked to record their answers and encouraged to share responses with others.

The narrative was first read in pairs and then as a class. Unfamiliar words and phrases were identified and discussed, then written on the board to reinforce comprehension. Before proceeding to the reflective exercises, students were asked to work in pairs to research cultural aspects embedded in the narrative. In the case of this particular narrative, students used the Internet to find examples of both Korean and German foods, in order to gain an appreciation of the ways in which these two cuisines traditionally differ. The pairs were then given time to briefly outline these differences.

Students were then asked to reflect on the narrative. Taking the perspective of the woman in the story, they were asked to imagine what she thought and felt when first confronted with smelly cheese.

A second form of reader reflection involved asking the students to place themselves in the position of the protagonist, in other words, to imagine how they would think, feel, and act if they encountered smelly cheese in a foreign supermarket. Students were then also asked to reflect on the broader immigrant experience of leaving behind familiar foods to live in a culture where they found many foods unfamiliar and unpalatable. In this way, students are given the opportunity to express the protagonist's perspective in their own words, and consider might experience life as a member of another culture. For the remainder of the class, the students were separated into small groups to share their reflections.

This teaching approach is grounded in the research conducted by Ornaghi, Brockmeier, and Grazzani (2014), in which groups of readers were divided into a reader-reflection group and a control group. The first group in this research was asked to reflect on the thoughts and feelings of the characters in the story. The control was not asked to do this. Both groups were then given a post-reading task unrelated to the story. The subjects in the reader-reflection groups scored considerably higher on an empathy instrument than the subjects in the control group.

Conclusion

However powerful a narrative is, reading it is not enough. Studies from narrative medicine consistently indicate that following reading with written reflection is vital. By writing down their thoughts, learners are given the opportunity to engage in perspective-taking. Students consider not only

how the characters in a story think and feel, but also how they themselves would think and feel in a similar situation. Small group and classroom discussions give learners the opportunity to share their thoughts and discoveries and to learn from others. These strategies compensate for the weakness inherent in didactic methods to create awareness and sensitivity.

Despite broad agreement for the inclusion of cultural components in foreign-language education, questions concerning which aspects of culture to incorporate and how to teach them, remain continued topics of debate. This research has introduced examples from the field of narrative medicine, in which literature is used in an empathy-centered approach to increase physician awareness and understanding of patient needs. Strategies involving narrative reading, written reflection, and discussion promote learner ability to engage in perspective-taking, and help physicians to bridge age, health, socioeconomic, and cultural differences. For foreign-language educators, narrative medicine provides a novel approach to incorporating cultural components in existing EFL/ESL curricula. Through engagement in perspective-taking through reading, reflecting, and discussing stories written from alternate cultural backgrounds, learners develop the ability to shift cultural perspectives essential for the acquisition of intercultural communicative competence.

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